Memorandum

To: LeadingAge Connecticut Members

From: Maureen Weaver and Jody Erdfarb, Wiggin and Dana LLP

Date: October 24, 2022

Re: Connecticut Law Related to the June 29, 2022 CMS RoPs Guidance

INTRODUCTION

As you know, Phase 3 of the Requirements of Participation (RoPs) went into effect in November 2019. After a three-year delay, CMS finally issued RoPs Phase 3 surveyor guidance through revisions to the State Operations Manual, Appendix PP on June 29, 2022. In addition to Phase 3 guidance, the June 29, 2022 version of the guidance also contains revisions to sections of the existing guidance for Phase 1 and 2 in areas such as resident rights, abuse and neglect, admission, transfer/discharge, and various other requirements. The implementation deadline for the revised guidance is **October 24, 2022**.

The revised State Operations Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities is available at: https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf.

LeadingAge national has developed implementation checklists, tool kits and other resources to assist members in complying with the revised RoPs guidance, and we assume that many of you may have already accessed these resources to review and revise your policies and procedures. The purpose of this Memorandum is to highlight areas addressed in the revised guidance with associated provisions under Connecticut law that either conflict with or expand upon the federal requirements.

The following is a list of all Appendix PP F tags that CMS revised as of June 29, 2022. For the most part, there are no significant Connecticut law implications for many of the revised F tags. However, in certain areas such as visitation, abuse/neglect reporting, transfer/discharge, readmissions, staffing, and infection control, Connecticut has enacted more detailed and specific requirements that must be followed. Some requirements have been enacted within the last two years; others have been in effect for some time but are included as a reminder to ensure that you address them in any revised policies or checklists developed based on the June 22, 2022 RoPs

guidance and LeadingAge national's resource materials. Where there are Connecticut requirements to consider, we've briefly summarized them. If there are no relevant Connecticut requirements, we've noted "no state impact."

CONNECTICUT LAW ANALYSIS

I. §483.10 Resident Rights

1. F557 Respect, Dignity / Right to Have Personal Property **(No state impact)**

2. F561 Self Determination **(No state impact)**

3. F563 Right to Receive/Deny Visitors

- CMS' new guidance states that a resident's family members should not be subject to visiting hour limitations or other restrictions not imposed by the resident, except for reasonable clinical and safety restrictions, consistent with §483.10(f)(4)(v), placed by the facility based on recommendations of CMS, CDC, or the local health department. "With the consent of the resident, facilities must provide 24-hour access to other non-relative visitors, subject to reasonable clinical and safety restrictions. Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life."

- Facilities should note that Connecticut law, CGSA[1] § 19a-535e (Public Act 21-71), allows a nursing home or a "resident representative"[2] to designate a "primary essential support person" and a "secondary essential support person"[3] who may visit the resident despite general visitation restrictions imposed on other visitors, provided the primary essential support person or secondary essential support person complies with any rules promulgated by the Commissioner of Public Health pursuant to section 19a-535f to protect the health, safety and well-being of long-

[1] CGSA refers to the Connecticut General Statutes Annotated.

[2] According to DPH's guidance, a "representative" means: (A) a court appointed health care representative; (B) "health care representative" as defined in chapter 368w; (C) designation of person for decision-making and certain rights and obligations as documented in section 1-56r; or (D) if such representative has not been legally appointed, means the resident's representative, such as a guardian, who makes health-care decisions on the resident's behalf, or a resident-selected representative who participates in making decisions related to the resident's care or well-being, including but not limited to, a family member or an advocate for the resident. The resident determines the role of the representative, to the extent possible.

[3] A "primary essential support person" means a person designated by a resident, or a resident representative, who may visit with the resident in accordance with rules set by the Commissioner of Public Health to provide essential support as reflected in the resident's person-centered plan of care. A "secondary essential support person" means a person designated by the resident, or resident representative, to serve as a backup to the primary essential support person.

term care facility residents. Section 19a-535f requires that DPH establish a state-wide policy for visitation with a long-term care resident. The policy must address visitation during public health emergencies and the role of the essential support person.

- DPH issued the state-wide policy, "Policies and Procedures for Essential Support Persons, and State-wide Visitation for Residents of Long-Term Care Facilities" (guidance), effective April 1, 2022. The DPH policy requires facilities to have policies for visitation in the facility and for the appointment of a primary and secondary essential support person. That support person must be provided access to the resident not less than twelve hours per day, even during a public health and civil preparedness emergency, provided the access shall not endanger the health or safety of the resident or other residents. If end of life care is taking place for the resident, the primary or secondary essential support person must have unrestricted access.

- According to DPH, the appointed primary or secondary essential support person may not be denied access to the resident unless the facility demonstrates that the person poses a danger to the health or safety of the resident or other residents, including the primary or secondary essential support person's ability to comply with any policies or protocols in place, or pending allegations pursuant to section 42 CFR 483.12 (Freedom from Abuse, Neglect, and Exploitation). If access is denied, the facility must provide written justification to the primary or secondary essential support person, electronically or in writing via certified mail, within twenty-four hours of the denial of access. The justification shall include, but not be limited to the reason for denial.

- This new state law described above provides more detailed guidelines and additional access to visitors than provided under CMS guidance, which generally allow for reasonable clinical and safety restrictions on visitation. As noted, the Connecticut law requires the facility to permit an appointed primary/secondary essential support person with twelve hours of access per day, provided the access shall not endanger the health or safety of the resident or other residents, and also provides residents with unrestricted access to visitors in end-of-life cases. Facilities should follow the more specific DPH visitation guidance, which incorporates the 2021 requirements, to maintain compliance with both state and federal requirements. Please see the model visitation policy (2022 Policy on Essential Caregivers and Visitation for MRCs Template) that LeadingAge Connecticut developed in response to the April 1st DPH guidance.

4. F582 Medicare/Medicaid Coverage / Liability Notice **(No state impact)**

5. F584 Safe/Clean/Comfortable/Homelike Environment **(No state impact)**

II. §483.12 Freedom from Abuse, Neglect, and Exploitation

1. F600 Free from Abuse and Neglect

   - The new CMS guidance provides more details on the definition of "neglect," defining it as "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." According to the revised definition, neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person.

   - CGSA § 17b-450, which sets out definitions governing mandatory reports of elder abuse, defines "neglect" as the failure or inability of an elderly person to provide for himself or herself the services which are necessary to maintain physical and mental health or the failure to provide or arrange for provision of such necessary services by a caregiver. Since the state law definition is much narrower than the CMS definition and guidance, facilities should use the newly expanded CMS definition of neglect in their policies.

2. F604 Right to Be Free from Physical Restraints **(No state impact)**

3. F607 Develop/Implement Abuse/Neglect, etc. Policies

   - Policies on pre-employment screening should reference the ABCMS background check process.

4. F609 Reporting of Crimes and Allegations of Abuse, Neglect, etc.

   - F609 addresses reporting requirements for "covered individuals" under the Elder Justice Act (relocated from F608 to F609). These "covered individuals" must report to the state survey agency and appropriate law enforcement authorities in cases where there is a reasonable suspicion that a crime has occurred against a facility resident. Under F608, the timeframe for reporting is "immediately" if there is serious bodily injury and no later than 2 hours after forming the reasonable suspicion of a crime. If there is no serious bodily injury, the report must be made within 24 hours.

- As a reminder, Connecticut law (CGSA § 19a-553) requires that a nursing home administrator file a detailed statement regarding any alleged commission of any crime or criminal action by any patient, employee or visitor to the appropriate local law enforcement agency.

- F609 also addresses a facility's obligation to report allegations of abuse, neglect, exploitation and mistreatment, including injuries of unknown source, involving a resident. The report must be made to the facility administrator and "other officials" including the state survey agency and adult protective services within 2 hours after receiving the allegation, if the alleged violation involves abuse or results in serious bodily injury, and not later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment or misappropriation of resident property and does not result in serious bodily injury. (Note that the revised CMS guidance for F609 contains helpful guidelines for determination when resident-to-resident altercations may rise to the level of a reportable event).

- Federal law requires that reports be made to "adult protective services where state law provides for jurisdiction in long-term care facilities." We do not have an "adult protective services" in Connecticut, but DPH has taken the position during surveys that facilities should comply with this requirement by reporting to DSS pursuant to CGSA § 17b-451, which mandates specified individuals to report to DSS Elderly Protective Services when there is reason to suspect or believe that an elderly person has been abused, neglected, exploited or abandoned or is in a condition that is the result of such abuse, neglect, exploitation or abandonment, or is in need of protective services.

- CGSA § 17b-451 (Public Act 22-145) was recently amended to require that a mandatory reporter who has reasonable cause to suspect or believe that any elderly person has been abused, neglected, exploited or abandoned, or is in a condition that is the result of such abuse, neglect, exploitation or abandonment, or is in need of protective services, shall, not later than 24 hours after such suspicion or belief arose, report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services or to the person or persons designated by the commissioner to receive such reports. The previous timeframe for reporting was 72 hours but now the report must be made within 24 hours. Note that to ensure compliance with the federal requirements, facilities should report to DSS Elderly Protective Services any reasonable suspicion or belief of abuse, neglect, exploitation or mistreatment within two hours if abuse or serious injury is involved.

- Pursuant to Regs. Conn. State Agencies § 19-13-D8t, a complaint of patient abuse or an event that involves an abusive act to a patient by any person (including verbal, mental, sexual, or physical attack on a patient that may include the infliction of injury, unreasonable confinement, intimidation, or punishment) must be reported

immediately to DPH. We understand that DPH follows the CMS reporting timeframes for purposes of the obligation to report "immediately."

- As a reminder, DPH requires that the facility submit a written report of its investigation within 72 hours after the reportable event has been filed; this is shorter than the five-business day CMS timeframe for investigative reports.

III. §483.15 Admission, Transfer, and Discharge

1. F622 Transfer and Discharge Requirements

- As a reminder, facility policies on transfer and discharge should also follow Connecticut requirements (CGSA § 19a-535 for transfer/discharge and CGSA § 19a-537 for readmission following hospitalization).

- In terms of nonpayment as a basis for discharge, note that Connecticut provides that a facility may involuntarily discharge a self-pay resident who is more than 15 days in arrears. The CMS regulation references failure to pay "after reasonable and appropriate notice." Facilities can apply the more specific Connecticut timeframe, but should be sure to document notice to the resident of the overdue account.

- For emergency transfers to acute care in terms of returns to the facility after hospitalization, facilities should follow CGSA § 19a-537's provisions on readmission from the hospital, including provisions for the consultative process (see discussion below under F626) and the requirements concerning refusal to readmit, when the basis for refusing to readmit relates to the hospitalization (i.e. the facility determines the resident's condition has not stabilized and it cannot safely care for the resident). However, if the facility does not want to readmit the resident for an unrelated reason (i.e. resident sent to hospital for medical reason but is in arrears on payments), then the facility should follow the process in CGSA § 19a-535.

- Note that F622's guidance states that a resident has a right to return to the facility from the hospital pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. However, CGSA § 19a-537 does not require that a facility refusing to readmit a resident from the hospital must allow the resident to return pending appeal. It may be possible to reconcile the two requirements, particularly when the facility is refusing to readmit because it determines that the resident is not ready to return to the facility due to the potential that the resident or others could be endangered. On the other hand, if, as described above, the facility has initiated involuntary discharge for a reason unrelated to the hospitalization (e.g. non-payment), then the resident should be readmitted pending the appeal.

2. F623 Notice Requirements Before Transfer/Discharge

   - As with Connecticut law, F623 requires that the facility provide a copy of any notice of involuntary transfer/discharge to the State Long-Term Care (LTC) Ombudsman. Note that CGSA § 19a-535 (Public Act 22-57) requires facilities to report each involuntary transfer or discharge notice and refusal to readmit notice to the State Ombudsman on an internet portal maintained by the Ombudsman. Instructions are available at: https://portal.ct.gov/-/media/LTCOP/PDF/WEBPORTAL/LTCOP-INV-Transfer-Website-Help-Manual-For-Facility-Staff-V1-11-2-21.pdf.

   - The CMS guidance now states that the notice must include the "specific location" (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred/discharged. CGSA § 19a-535 simply states that the notice must indicate the discharge/transfer "location." The revised CMS guidance could raise issues because it is not always possible to identify a specific location at the time the notice is provided and so it is possible the notice could be found to be invalid if the transfer/discharge is appealed, or if the notice is reviewed during a federal survey.

   - The CMS regulation requires that the notice be given at least 30 days prior to the proposed transfer or discharge. Reminder that CGSA § 19a-535 contains the additional requirement that the notice may not be given more than 60 days before the proposed transfer or discharge.

3. F624 Preparation for Safe/Orderly Transfer/Discharge **(No state impact)**

4. F626 Permitting Residents to Return to Facility

   - The revised CMS guidance states that the facility must have policies on permitting the resident to return to the facility after they are hospitalized or on therapeutic leave. The policy must provide that residents seeking to return to the facility within the bed-hold period are allowed to return to their previous room, if available. Additionally, residents who seek to return to the facility after the expiration of the bed-hold period must be allowed to return to their previous room if available, or immediately to the first available bed in a semi-private room provided that the resident still requires the services provided by the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services. The policies must also provide that if the facility determines that a resident cannot return, the facility must comply with the requirements for involuntary transfers and discharges, since the

decision not to allow a resident to return to the facility would be considered a facility-initiated discharge.

- Facilities should note that CGSA § 19a-537 provides a consultative process in cases when a nursing home has concerns about the readmission of a resident based on whether the nursing home can meet the resident's care needs or the resident presents a danger to himself or herself or to other persons. Not later than twenty-four hours after receipt of notification from a hospital that a resident is medically ready for discharge, a nursing home must request a consultation with the hospital and the resident or the resident's representative. The purpose of the consultation is to develop an appropriate care plan to safely meet the resident's nursing home care needs, including a determination of the date for readmission that best meets such needs. The resident's wishes and the hospital's recommendations must be considered as part of the consultative process. The nursing home must reserve the resident's bed until completion of the consultative process. The consultative process must begin as soon as practicable and be completed not later than three business days after the date of the nursing home's request for a consultation. The hospital must participate in the consultation, grant the nursing home access to the resident in the hospital and permit the nursing home to review the resident's hospital records.

IV. §483.20 Resident Assessments (No state impact)

1. F641 Accuracy of Assessments

V. §483.21 Comprehensive Resident Centered Care Plan (No state impact)

1. F656 Develop/Implement Comprehensive Care Plan
2. F658 Services Provided Meet Professional Standards
3. F659 Qualified Persons

VI. §483.24 Quality of Life (No state impact)

1. F675 Quality of Life
2. F679 Activities Meet Interest/Needs of Each Resident

VII. §483.25 Quality of Care

1. F686 Treatment/Services to Prevent/Heal Pressure Ulcers **(No state impact)**

2. F687 Foot Care **(No state impact)**

3. F689 Free of Accident Hazards / Supervision / Devices **(No state impact)**

   - Note that there is no state impact here, since the Connecticut licensure regulations are narrower and simply provide that that "number, qualifications, and experience of [nursing] personnel shall be sufficient to ensure that each patient . . . (C) is protected from accident incident, infection, or other unusual occurrence." Facilities should follow the federal guidance.

4. F690 Bowel/Bladder Incontinence, Catheter, UTI **(No state impact)**

5. F694 Parenteral/IV Fluids

   - CMS guidance states that there is no federal requirement that a facility offer IV therapy. Note, however, CGSA § 19a-563c (Public Act 21-185) requires that the administrative head of each nursing home ensure that there is at least one staff member or contracted professional licensed or certified to start an intravenous line and who is available on-call during each shift to start an intravenous line if needed.

   - The CMS guidance states that the facility must ensure that individuals providing IV therapy are qualified, trained, and competent in accordance with professional standards of practice, licensure and state practice acts/laws. In Connecticut, pursuant to CGSA § 19a-522f (Public Act 21-121), an "IV therapy nurse" (a registered nurse who is qualified by education and training and has demonstrated proficiency in the theoretical and clinical aspects of IV therapy to administer an IV fluid or IV admixture) or a physician assistant may administer a peripherally inserted central catheter. In addition, a registered nurse employed by the facility who has been properly trained by the director of nursing or by an intravenous infusion company may (1) administer IV therapy or a dose of medication by intravenous injection, provided such medication is on a list of medications approved by the facility's governing body, pharmacist and medical director for intravenous injection by a registered nurse, or (2) draw blood from a central line for laboratory purposes, provided the facility has an agreement with a laboratory to process such specimens. Facilities providing these services must notify the DPH Commissioner. In addition, the facility's administrator must ensure that each RN who is permitted to provide the services is appropriately trained and competent to provide these services. The nursing home administrator must maintain records of the training and competency of each RN and must make such records available for inspection by DPH upon request.

   - Note that Regs. Conn. State Agencies § 19-13-D8u addresses the administration of IV therapy but has not yet been updated in accordance with the recently

enacted statutes. The regulation is clear that only a physician may initiate and terminate a central vein access.

6. F695 Respiratory/Tracheostomy Care and Suctioning **(No state impact)**

7. F697 Pain Management **(No state impact)**

8. F699 Trauma Informed Care **(No state impact)**

9. F700 Bed Rails

- CMS requires that a facility attempt to use appropriate alternatives before installing a side or bed rail. However, Connecticut licensure requirements require that each resident room contain an adjustable hospital bed with side rails. As a result, facilities should follow the federal requirements – while the bed rails will have been installed, alternatives to using them should be attempted and documented before use of bed rails is included in the care plan.

VIII. §483.30 Physician Services

1. F712 Physician Visits – Frequency/Timeliness/Alternate NPPs

- CMS requires that a physician perform the initial visit and then visit every 30 days for the first 90 days after admission and then every 60 days thereafter. At the option of the attending physician, after the initial visit, the visits can alternate between a physician and either an APRN, PA or CNS. The Public Health Code § 19-13-D8t(n) does not provide for alternate visits between a physician and APRN/PA/CNS. However, it does permit the physician, after 90 days, to establish a less frequent timeframe for visit intervals as long as the reason is documented in the resident's record and the alternative schedule does not at any time exceed 60 days. This is consistent with the federal requirement. This is one item that will need to be clarified with DPH, particularly given the many recent changes in the law expanding the authority of APRNs and PAs.

IX. §483.35 Nursing Services

1. F725 Sufficient Nursing Staff

- CMS staffing requirements for nurses and nurse aides do not include minimum staffing ratios, but Connecticut has enacted a requirement that DPH establish minimum staffing requirements for nursing homes of three hours of direct care per resident per day. In addition, DPH must establish minimum staffing requirements for social workers and recreation staff; the minimum requirement for social workers is one full-time social worker for every 60 residents applied

proportionally based on the number of residents in the nursing home. CGSA § 19a-563h and Public Act 22-58, § 36.

- Also, CMS requires one licensed nurse to serve as charge nurse for each tour of duty, but DPH licensure regulations require that there be at least one licensed nurse on duty on each patient occupied floor at all times. Regs. Conn. State Agencies § 19-13-D8t(m)(4)(A).

2. F727 RN 8 Hrs/7 days/Week, Full Time DON

   - F727 only requires an RN in the facility 8 hours a day, 7 days a week. However, Connecticut law requires an RN in the facility 24/7. Regs. Conn. State Agencies § 19-13-D8t(m)(4).

3. F729 Nurse Aide Registry Verification, Retraining (**No state impact**)

   - Note that Connecticut law requires any person employed for more than 120 days as a nurse's aide in a nursing home to have already successfully completed a training and competency evaluation program approved by DPH and be entered on the nurse's aide registry maintained by DPH.

4. F732 Posted Nurse Staffing Information

   - Reminder that Connecticut has enacted statutes to implement this requirement. CGSA § 19a-562f through § 19a-562h. The statute tracks the federal requirement but with a few exceptions:

     - In addition to posting the total number of RNs, LPNs and CNAs who will be responsible for direct care during each shift, the facility must also post the total number of APRNs involved in direct care for that shift.

     - Also, Connecticut requires that the posting include:

       - The minimum number of nursing facility staff per shift required by state regulations to be responsible for providing direct patient care to residents of the nursing home (as noted above, the minimum in Connecticut is three hours of direct care per resident per day).

       - The telephone number or Internet web site that a resident, employee or visitor may use to report a suspected violation by the nursing facility of regulatory requirements concerning staffing levels and direct patient care.

X. §483.40 Behavioral Health (No state impact)

1. F740 Behavioral Health Services
2. F741 Sufficient/Competent Staff – Behavioral Health Needs
3. F742 Treatment/Svc for Mental/Psychosocial Concerns
4. F743 No Pattern of Behavioral Difficulties Unless Unavoidable
5. F744 Treatment/Service for Dementia

XI. §483.45 Pharmacy Services (No state impact)

1. F755 Pharmacy Services / Procedures / Pharmacist / Records
2. F758 Free from Unnecessary Psychotropic Meds / PRN Use

XII. §483.60 Food and Nutrition Services (No state impact)

1. F812 Food Procurement, Store/Prepare/Serve – Sanitary

XIII. §483.70 Administration (No state impact)

1. F847 Enter into Binding Arbitration Agreements
2. F848 Select Arbitrator/Venue, Retention of Agreements
3. F851 Payroll Based Journal

XIV. §483.75 Quality Assurance and Performance Improvement (No state impact)

1. F865 QAPI Program/Plan, Disclosure / Good Faith Attempt
2. F867 QAPI/QAA Improvement Activities
3. F868 QAA Committee

XV. §483.80 Infection Control (See LeadingAge Policy and Procedure Checklist)

1. F880 Infection Prevention & Control

- F880 contains detailed guidance on facility infection and prevention programs. In addition to following the federal requirements and guidance, facilities need to ensure compliance with Connecticut law enacted in 2021 (Public Act 21-185 codified at CGSA § 19a-563d) requiring that each facility's infection prevention and control committee (IPCC) meet monthly and daily during an infectious disease outbreak so long as daily meetings do not disrupt operations of the home, in which case the IPCC should meet at least weekly. The IPCC is responsible for establishing infection prevention and control protocols and for monitoring the nursing home's s infection prevention and control specialist (IPCS). At least annually and after every disease outbreak, the IPCC must evaluate the implementation and outcome of the protocols and whether the IPCS is satisfactorily performing his or her duties. CGSA § 19a-563d.

2. F881 Antibiotic Stewardship Program **(No state impact)**

3. F882 Infection Preventionist Qualifications/Role

- CMS requires that the facility designate one or more individuals as the infection preventionist (IP) who is responsible for assessing, developing, implementing, monitoring and managing the facility's infection prevention program. The IP must have primary professional training in nursing, medical technology, microbiology, epidemiology or other related field; be qualified by education, experience, certification; work at least part-time at the facility and have completed specialized training in infection prevention and control.

- Although the federal requirements indicate that the IP must work "at least part-time," Connecticut requires that in a facility with more than 60 residents, the IP must serve in that position full-time. Facilities with 60 or fewer residents may employ an IP part-time. Furthermore, the IP may provide services to both a nursing home and a dementia special care unit or to two nursing homes if: (i) the nursing and dementia special care unit or the two nursing homes are located next to one another or on the same campus and commonly owned or operated; and (ii) the owner or operator of the facilities submits a written request to the Commissioner of DPH (or the designee) asking whether the IP can work at both locations. Of note, the IP cannot start working at both locations until the owner/operator receives approval of the written request from the Commissioner of DPH or the Commissioner's designee.

- Connecticut law also specifies certain specific duties of the IP: (1) ongoing training of administrators and employees on infection prevention and control using multiple training methods, including in-person training and written materials in English and Spanish; (2) providing information on infection prevention and control both in the documentation that the nursing home provides to residents and posting this information in areas visible to residents;

(3) participation as a member of the IPCC of the nursing home and reporting to the committee at its regular meetings about the training provided; (4) providing training on infection prevention and control methods to supplemental or replacement staff of the nursing home in the event that a disease outbreak or other situation reduces staffing levels; and (5) any other duties deemed appropriate by the nursing home. In addition, nursing homes must require their IPs to implement procedures to monitor daily shifts and ensure that they comply with infection prevention and control standards.

- The law permits the Commissioner of DPH to waive any of these requirements so long as the Commissioner determines that doing so would not endanger the life, safety or health of residents and employees. If the Commissioner waives any requirement, the Commissioner may also impose conditions to ensure the health, safety and welfare of residents and employees. The Commissioner may also revoke the waiver upon a finding that the health, safety or welfare of any nursing home or dementia special care unit employee is jeopardized by the waiver.

  CGSA § 19a-563 amended by Public Act 22-58, § 52.

4. F883 Influenza and Pneumococcal Immunizations **(No state impact)**

XVI. §483.85 Compliance and Ethics (No state impact)

1. F895 Compliance and Ethics Program

XVII. §483.90 Physical Environment (No state impact)

1. F919 Resident Call System

   - Note that the CMS guidance requires that the call system be accessible to a resident lying on the floor.

XVIII. §483.95 Training Requirements

1. F940 Training Requirements – General

   - CMS recognizes that training needs are likely to change over time and, therefore, requires facilities to have the flexibility to determine training needs based on the facility assessment. Connecticut law specifically requires that all staff receive in-service training by a qualified social worker or qualified social work consultant each year in an area specific to the needs of the facility's patient population. Regs. Conn. State Agencies § 19-13-D8t.

2. F941 Communication Training **(No state impact)**

3. F942 Resident Rights Training

    - CMS requires that this training occurs, but Connected law specifies that all staff of the facility must receive in-service training by or under the direction of a qualified social worker or social work designee each year concerning patients' personal and property rights pursuant to Section 19a-550 of the Connecticut General Statutes. Regs. Conn. State Agencies § 19-13-D8t.

    - Connecticut law also requires that the nursing home administrator ensure that all facility staff receive annual in-service training in an area specific to the needs of the patient population at such facilities, including patients' fear of retaliation from employees or others. The nursing home administrator is also required to ensure that any person conducting the in-service training is familiar with needs of the patient population at the facility, provided such training need not be conducted by a qualified social worker or qualified social worker consultant. The nursing home administrator is required to ensure that the in-service training in patients' fear of retaliation includes discussion of (1) patients' rights to file complaints and voice grievances, (2) examples of what might constitute or be perceived as employee retaliation against patients, and (3) methods of preventing employee retaliation and alleviating patients' fear of such retaliation. CGSA § 19a-522c.

4. F944 QAPI Training **(No state impact)**

5. F945 Infection Control Training

    - Federal regulation requires each facility to include mandatory training as part of its infection prevention and control program, but note that Connecticut law requires that each nursing home's infection prevention and control specialist must also conduct ongoing training of all administrators and employees of the nursing home on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish. CGSA § 19a-563. In addition, infection control is now a mandatory topic for nursing home administrators' continuing education. See Public Act No. 22-58 §11.

6. F946 Compliance and Ethics Training **(No state impact)**

7. F947 Required In-Service Training for Nurse Aides

- F947 requires that a facility provide at least 12 hours of training annually to nurse aides, including dementia management training and abuse training. The training must address the care of cognitively impaired residents if the nurse aide provides care to such residents, weaknesses identified in the nurse aide's performance review and any special resident needs identified in the facility assessment.

- Under Connecticut law (CGSA § 19a-562a, discussed in more detail below), each nursing home must provide to all nurse aides (as well as all licensed direct care staff): (i) a minimum of two hours of training annually in pain recognition and administration of pain management techniques and (ii) a minimum of one hour of training in oral health and oral hygiene techniques no later than one year after the date of hire and annually after the initial training.

8. F949 Behavioral Health Training **(No state impact)**

Comments on Additional State Law Training Requirements

In addition to the CMS mandated subject-matter specific training, state law requires:

- All personnel must receive training in emergency preparedness as part of their employment orientation. Staff shall be required to read, and acknowledge by signature, their understanding of the emergency preparedness plan as part of the orientation. The content and participants of the training orientation must be documented in writing. Regs. Conn. State Agencies § 19-13-D8t.

- If a nursing facility does not have a dementia special care unit or program, the facility must (1) annually provide a minimum of two hours of training in pain recognition and administration of pain management techniques, and (2) provide a minimum of one hour of training in oral health and oral hygiene techniques not later than one year after the date of hire and subsequent training in said techniques annually thereafter, to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents.

- A dementia special care unit or program must annually provide Alzheimer's and dementia specific training to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents enrolled in the dementia special care unit or program. The training must include, but not be limited to, (1) not less than eight hours of dementia-specific training, which must be completed not later than six months after the date of employment or, if the date of employment is on or after October 1, 2014, not later than 120 days

from the date of employment and not less than eight hours of such training annually thereafter, and (2) annual training of not less than two hours in pain recognition and administration of pain management techniques for direct care staff. Each dementia special care unit or program must also annually provide a minimum of one hour of Alzheimer's and dementia specific training to all unlicensed and unregistered staff, except nurse's aides, who provide services and care to residents enrolled in the dementia special care unit or program. For such staff hired on or after October 1, 2007, training must be completed not later than six months after the date of employment and, for such staff hired on or after October 1, 2014, not later than 120 days after the date of employment. CGSA § 19a-562a.